Section 5

Reflections

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This section is designed to identify lessons learned by the State during the early implementation of its SCHIP program as well as to discuss ways in which the State plans to improve its SCHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your SCHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

Answer by completing the following.

5.1.1 Eligibility Determination/Redetermination and Enrollment

- The AHCCCS Administration made a considerable effort to limit the eligibility application to a one page (front and back), dual SCHIP/MEDICAID application. Although a laudable goal, it is impossible to keep the information that sparse and try to complete the case without a face-to-face interview. The application is now two pages (front and back) and one of the sides is signature only. Increasing the size of the application allowed us to enlarge the font, clarify problematic areas and include clearer instructions for completion of the form and submission of verification. Our new multicolored form allows for highlighting important sections that were previously missed.

- Our streamlined verification process has been very effective and allows us to accept declaration for virtually every eligibility element other than income and citizenship, if born outside the U.S. We are not experiencing any significant error rates using declared data. KidsCare staff obtain a large percentage of the required verification collaterally, eliminating the time and expense of obtaining hard copies of documents.

- The Department of Economic Security is responsible for determining eligibility for Title XIX. In order to expedite the eligibility determination (for both KidsCare and Title XIX) we established a co-located eligibility unit of DES staff within the KidsCare Office. Having Title XIX eligibility interviewers in the same office as KidsCare staff enables AHCCCS to detect and correct mistakes or omissions. The close proximity of Title XIX and KidsCare employees facilitates good communication between the two agencies.

- AHCCCS implemented a very effective automated process for identifying discontinued Title XIX children, who may be KidsCare eligible. These KidsCare eligibles are enrolled without an additional application, interview or documentation. These Title XIX children are subject to a 6-month renewal process, rather than the 12-month renewal for other KidsCare cases.

- The state has developed an authorization form signed by the applicants, which permits the state to notify advocacy groups that their clients have failed to provide some requested documentation. Advocacy groups plan to work with their clients to ensure they understand and comply with KidsCare redetermination requirements.

5.1.2 Outreach

- The 10 percent administrative cap of program dollars presents serious challenges to implementing and managing a new start-up program. Section 2105 of the Act requires states to limit spending to 10 percent on administrative expenditures. However, this restriction is at odds with the goal of providing creditable coverage to all potentially eligible children. Out of this 10 percent, states need to develop efficient, effective outreach and enrollment strategies and implement the administrative infrastructure (e.g. eligibility workers, computer programming, office space, phones, etc.). Maintaining outreach and program administration at 10 percent is difficult enough without the additional need to re-calculate CPS data, possibly running actuarial studies on each employer sponsored insurance benefit package, and supply wrap-around coverage on a FFS basis. AHCCCS realizes that the 10 percent is statutorily mandated; however, we encourage HCFA to pursue a Congressional change to provide more flexibility to the states.

- The emphasis on outreach has enabled states to enroll more children. In fact, the lessons learned from SCHIP can be applied to the Medicaid program. Arizona has received feedback that families would prefer having a choice to enroll children in KidsCare rather than Medicaid. Consequently, some families have refused to enroll their children in Medicaid, but would have enrolled their children in KidsCare if that choice had been made available. Therefore, requiring Medicaid enrollment seems at odds with efforts to decrease the number of uninsured children.

- The state of Arizona has worked to bridge enrollment processes for both Title XIX and Title XXI, ensuring eligible children are enrolled in the appropriate program. Not only has AHCCCS and DES developed a simplified dual application for both programs, these two agencies have interfaced automated eligibility systems to ensure that applicants do not get lost between the cracks.

5.1.3 Benefit Structure

- KidsCare's benefit structure is very similar to the Medicaid benefit structure. The differences include:

    - Non-emergency transportation is not provided,
    - Behavioral health inpatient and outpatient services are limited to 30 days each in a contract year, and
    - Eye exams and eyeglasses are limited to 1 a year.

- Since KidsCare has only been operating since November 1998 and uses encounters to evaluate service delivery, it is too early to evaluate the effectiveness of the program.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5 percent cap)

- Because the federal government requires states to repay 75 percent of the premiums collected, states lose monies collecting payments. If premiums are considered a viable way for states to manage and promote their programs (i.e., personal responsibility), the federal government needs to reduce administrative burdens with reporting cost-sharing and to share in the administrative costs to collect. This will assist the program.

5.1.5 Delivery System

- Although there are administrative and benefit differences between Medicaid and KidsCare, KidsCare was essentially incorporated into the Medicaid program's delivery system. All health plans and providers that participate in Medicaid participate in KidsCare. Therefore, there were no significant implementation issues pertaining to the delivery system.

  Health plans made adjustments to distinguish the two programs for providers, but health plans were essentially able to build KidsCare into their present operations, therefore reducing administrative costs. This allowed for a near trouble free implementation. AHCCCS evaluated the health plans' systems and publications and was able to verify that the networks were adequate. KidsCare members were properly assigned to primary care physicians, and program distinctions were made to participating providers and members.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

- SCHIP provisions do allow states to use public monies to subsidize family coverage in the private health insurance market. Family coverage would facilitate keeping children insured, keeping families together. Enrollment rates could be 30 percent higher when families enroll rather than children alone.[4] However, the current SCHIP program does not promote enough state flexibility.

- Arizona is interested in exploring the possibility of implementing employer-sponsored insurance (ESI). However, Congress or HCFA would need to reduce barriers and increase state flexibility in order for this to happen. For example, Arizona has concerns about the following inflexibility in:

  - Benchmark actuarial equivalence. This could be cost prohibitive. This requirement would require an actuarial opinion for each of the employer benefit packages. In addition, states without benchmark ESI programs would need "wrap-around" coverage for particular benefits that some commercial carriers do not cover.
  - Employer contributions of 60 percent. States need more flexibility in developing their own methods for employer contributions subject to HCFA approval.
  - Restriction of cost-sharing. Requiring states to ensure that all cost-sharing

[4] Alpha Center. State Initiatives in Health Care Reform 26 (May 1998): 1.

remains at statutorily mandated levels is unnecessarily administratively burdensome if states choose to insure members through ESI.

- Executive Order mandating the Patient's Bill of Rights. This order requires SCHIP members to be protected by the Patient's Bill of Rights. While this a noble idea, it makes ESI challenging. ESI by definition is enrollment into commercial plans. Congress has not mandated the Patient's Bill of Rights for commercial plans. Arizona would have to ensure that each member enrolled in a commercial plan had additional rights such as "anti-gag" protections, prudent layperson standards for emergency services and post-stabilization, and Medicaid standard for grievance and appeals. This then may increase administrative costs to monitor these additional requirements.

5.1.7 Evaluation and Monitoring (including data reporting)

- This evaluation is too early for states that implemented a program in late 1998. In addition, the administrative cap of 10 percent does not give states much latitude to hire an outside evaluation.

- Arizona is in the process of evaluating the KidsCare program. Since KidsCare only began in November 1998, a full year's worth of encounter is necessary before reliable conclusions can be made. The current evaluative time-frames did not provide enough time for this to occur.

5.1.8 Other (specify)

- AHCCCS is concerned that SCHIP eligibility requirements prohibit state employee's children under 200 percent FPL to have access to KidsCare. For example, a child who is eligible for a state health benefits plan is ineligible for SCHIP even though the child's family may be below poverty guidelines and be unable to afford even a nominal premium. AHCCCS realizes that the 10 percent is statutorily mandated; however, we encourage HCFA to pursue a Congressional change to provide more flexibility to the states.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

- The state of Arizona may consider implementing ESI, if state flexibility is given. Please see 5.1.6 above

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- To continue working with the federal government to find ways to increase state flexibility to promote innovation in providing health insurance as noted throughout Section 5.